

**NC Medicaid Pharmacy Prior Approval
Gocovri and Osmolex ER**



Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

7. Prescribing Provider NPI #: _____
8. Requester Contact Information
Name: _____ Phone #: _____ Ext. _____

Drug Information

9. Drug Name: _____ 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other: _____

Clinical Information

Initial Requests for Gocovri

1. Does the beneficiary have a diagnosis of dyskinesia due to Parkinson's disease? ☐ Yes ☐ No
2. Is the beneficiary receiving levodopa-based therapy with or without dopaminergic medications? ☐ Yes ☐ No
3. Is the beneficiary age 18 or older? ☐ Yes ☐ No
4. Does the beneficiary have any contraindications including ESRD (creatinine clearance < 15ml/min)? ☐ Yes ☐ No
5. Does the beneficiary have failure, contraindication, or intolerance to immediate-release amantadine (capsule, tablet, or oral solution)? ☐ Yes ☐ No
Please list: _____

Continuation Requests for Gocovri answer 1-5 above and 6 below:

6. Has documentation been attached to this request that indicates the beneficiary has had an improvement in his/her symptoms from baseline? ☐ Yes ☐ No

Initial Requests for Osmolex ER

1. Does the beneficiary have a diagnosis of Parkinson's disease or Drug-induced extrapyramidal reactions?
☐ Yes ☐ No
2. Is the beneficiary age 18 or older? ☐ Yes ☐ No
3. Does the beneficiary have any contraindications including ESRD (creatinine clearance < 15ml/min)? ☐ Yes ☐ No
4. Does the beneficiary have failure, contraindication, or intolerance to immediate-release amantadine (capsule, tablet, or oral solution)? ☐ Yes ☐ No
Please list: _____

Continuation Requests for Osmolex ER answer 1-4 above and 5 below:

5. Has documentation been attached to this request that indicates the beneficiary has had an improvement in his/her symptoms from baseline? ☐ Yes ☐ No

Signature of Prescriber: _____ Date: _____

**Prescriber Signature Mandatory*

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to NCTracks at (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505